# *Review of the VHA/DoD Clinical Practice Guideline for the Management of MAJOR DEPRESSIVE DISORDER IN ADULTS*

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# Overview

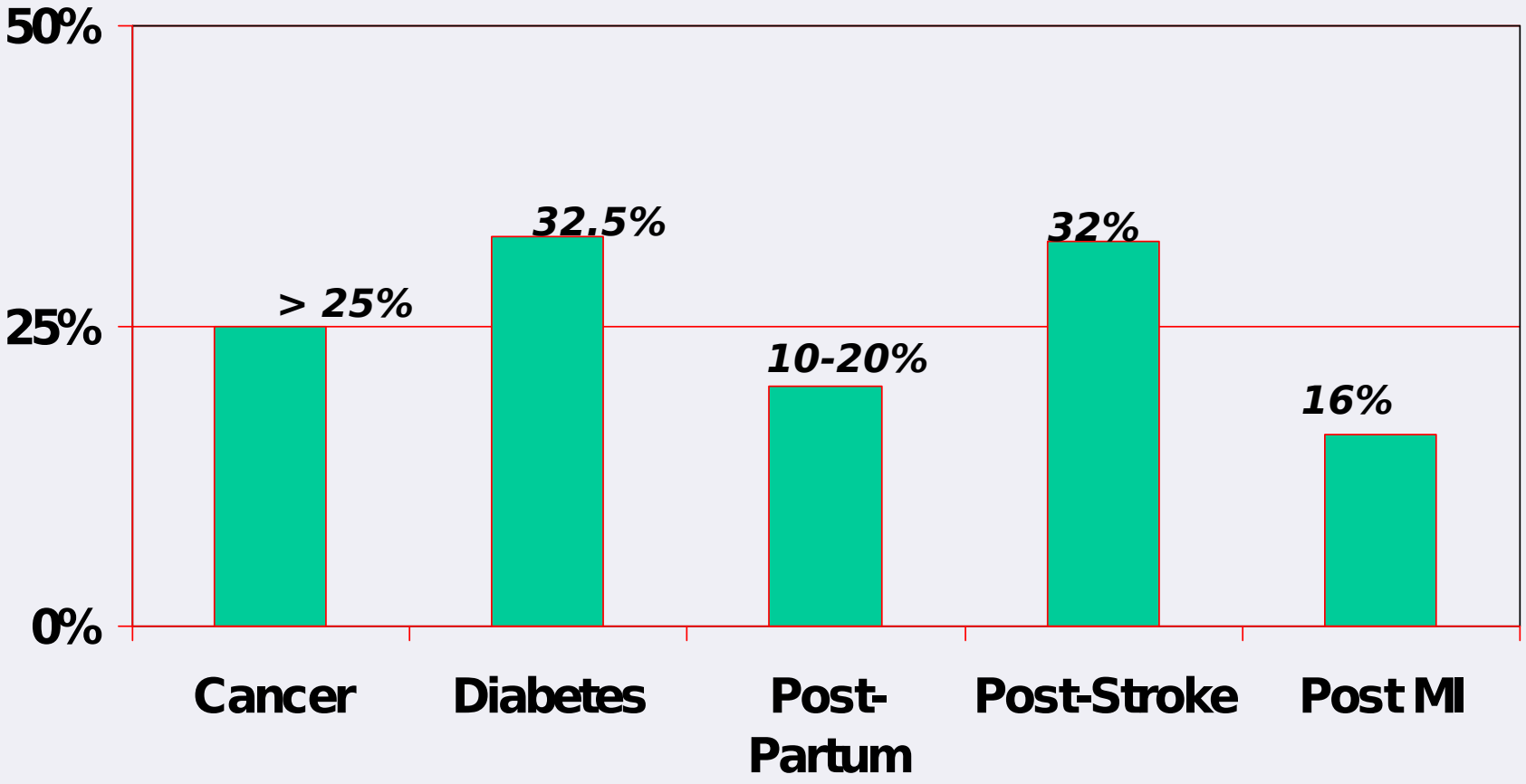
- Why a guideline for depression?
- Main guideline elements
- Guideline tools
- Guideline piloting
- Questions

# Why Depression?

# Major Depressive Disorder
## An Important Public Health Problem

- Common
- Detectable
- Reduces functioning & quality of life
- Associated with behavioral health risk (e.g., substance use disorders, STDs)
- Treatable
- Under-recognized & under-treated

# Depression as a Coexisting Condition




* Massie & Holland, 1995; Lustman et al, 1998;
Dobie & Walker, 1992; Morris et al, 1990

# ICD-9 Diagnoses – DoD CCEP Report

## 10,020 with Gulf War Concerns

| | Any Dx | Primary Dx |
|---|---|---|
| Musc-Skeletal | 45% | 17% |
| Ill-Defined | 41% | 17% |
| **Psychological** | **37%** | **19%** |
| Digestive | 22% | 6% |
| Dermatologic | 20% | 6% |
| Healthy | 19% | 11% |
| Respiratory | 18% | 7% |
| Nervous | 18% | 6% |
| Endocrine | 11% | 2% |
| Infectious | 9% | 3% |

# Work Days Lost – DoD CCEP

| | N | Days of Lost Work Total | Mean | % of All Lost |
|---|---|---|---|---|
| Psychological | 2,453 | 8,709 | 3.6 | 28.0% |
| Mood | 781 | 3,106 | 4.0 | 10.0% |
| Ill-Defined | 2,506 | 7,169 | 2.2 | 17.0% |
| Musculoskeletal | 2,351 | 6,757 | 2.0 | 15.2% |
| Neoplasm | 108 | 871 | 8.1 | 2.8% |
| Healthy | 1,183 | 866 | 0.7 | |

# Depression & Physical Symptoms

| Number of Symptoms | Number of Patients | Psychiatric Disorder N (%) Anxiety | Mood | Any |
|---|---|---|---|---|
| **Physical (N=1000)** | | | | |
| 0-1 | 215 | 2 ( 1) | 5 ( 2) | 16 ( 7) |
| 2-3 | 225 | 17 ( 7) | 27 (12) | 50 (22) |
| 4-5 | 191 | 25 (13) | 44 (23) | 67 (35) |
| 6-8 | 230 | 68 (30) | 100 (44) | 140 (61) |
| 9+ | 130 | 68 (48) | 84 (80) | 113 (81) |
| **Somatoform (N=900)** | | | | |
| 0 | 654 | 68 (10) | 107 (16) | 102 (25) |
| 1-2 | 143 | 42 (29) | 60 (42) | 74 (52) |
| 3-5 | 87 | 35 (40) | 40 (46) | 77 (89) |
| 6+ | 49 | 40 (55) | 34 (68) | 45 (94) |

Kroenke et al. Arch Fam Med 1994; 3:7

# MDD Guideline
## *Purpose*

- **To increase primary care awareness, diagnosis and treatment of MDD**

- **Part of the Army Surgeon General's goal to provide consistent and high quality health care**

# Guideline Development

- Representatives of VHA, Army, Navy, Air Force, and academia
- Primary care, psychiatrists, psychologists, social workers, administrators, and a chaplain
- Review evidence & develop guideline document
- Develop guideline implementation tools
- Pilot the guideline
- Adopt the guideline
- Intensify implementation efforts
- Reinitiate the process

# Depression Guideline Structure

## *Three Clinical Modules*

- Primary Care
- Outpatient Mental Health Care
- Inpatient Mental Health Care

# Main Guideline Points

- Screening
- Emergencies/Red Flags
- Depression Assessment
- Alternative Causes – Medical & Psychiatric
- Triage
- Review & Initiate Therapy
- Follow-up/Reassessment

# Primary Care
## *Initial Screening*

**Every patient screened once annually –**

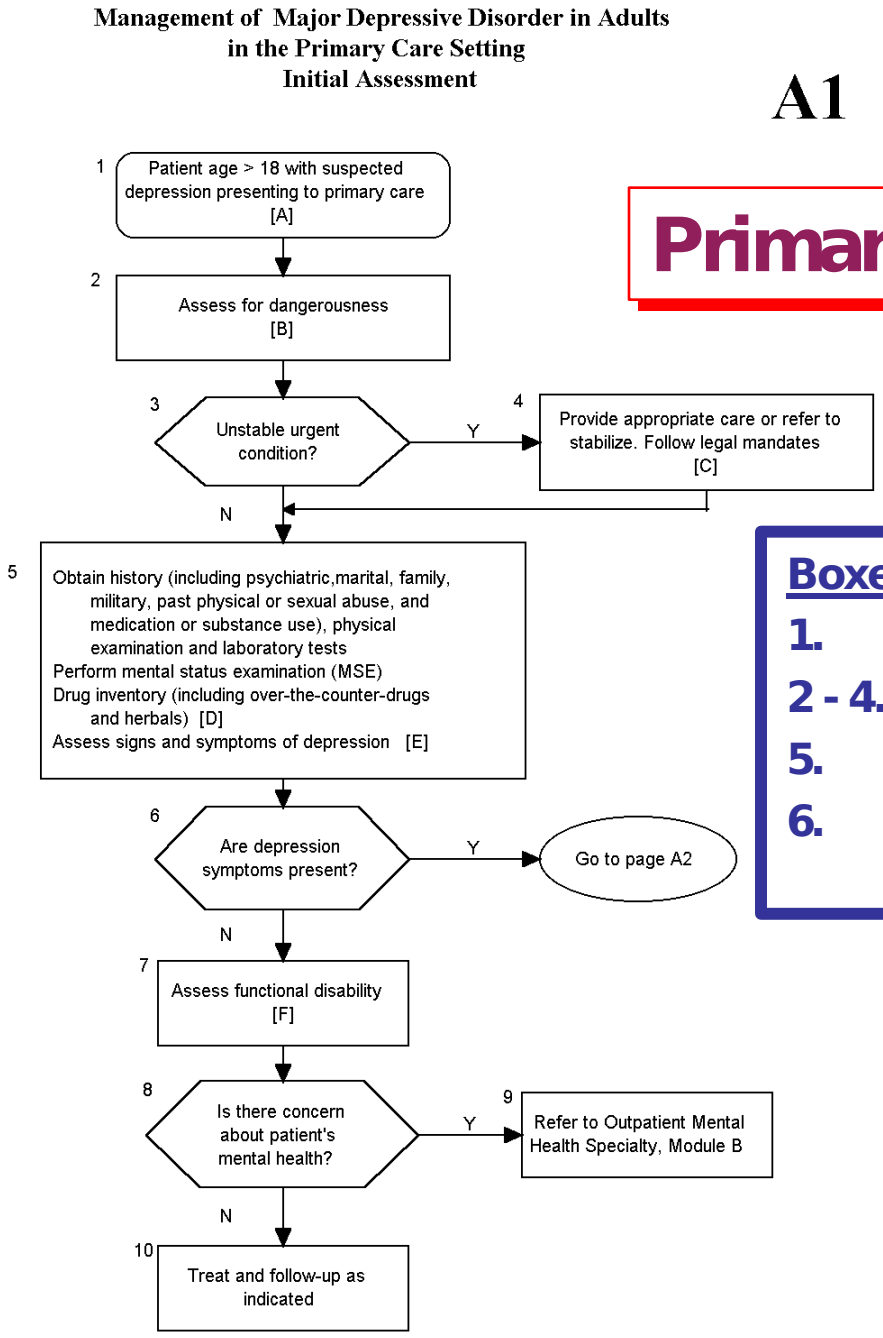
- **prior to seeing provider, unless diagnosis previously recorded**
- **two question screen (from Prime-MD)**
  - **Do you have little interest or pleasure in doing things?**
  - **Do you feel down, depressed or hopeless?**

# Tools for Guideline Implementation

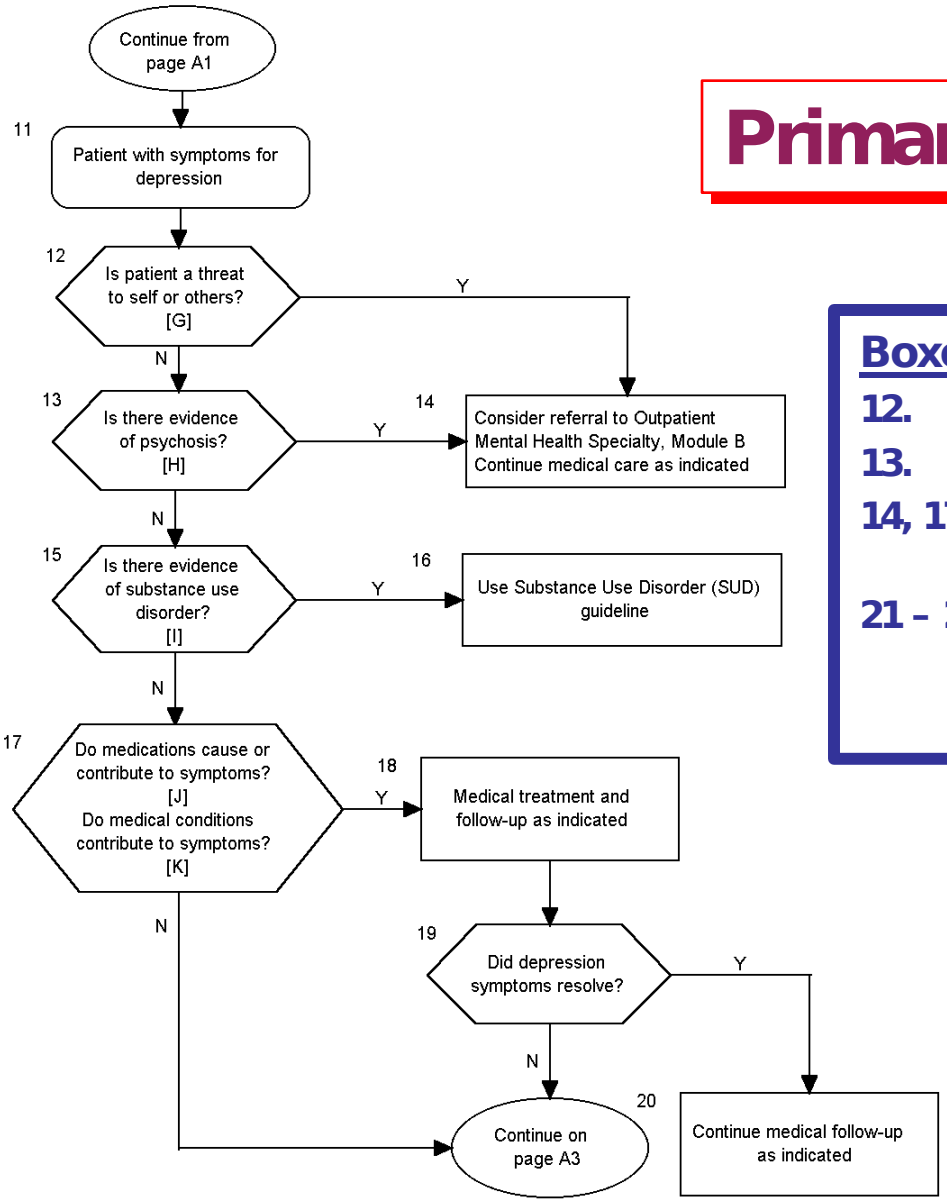
# Tools:
# Primary Care Provider Info

- Algorithms
- Depression Red Flags (urgent risk factors)
- Cage-Aid (comorbid alcohol assessment)
- SIG-E-CAPS (depression symptom assessment)
- Suicide & violence assessment
- Diagnostic criteria (MDD & Dysthymia)
- Patient education guidance
- Admission & referral criteria
- Antidepressant table

# Primary Care Module

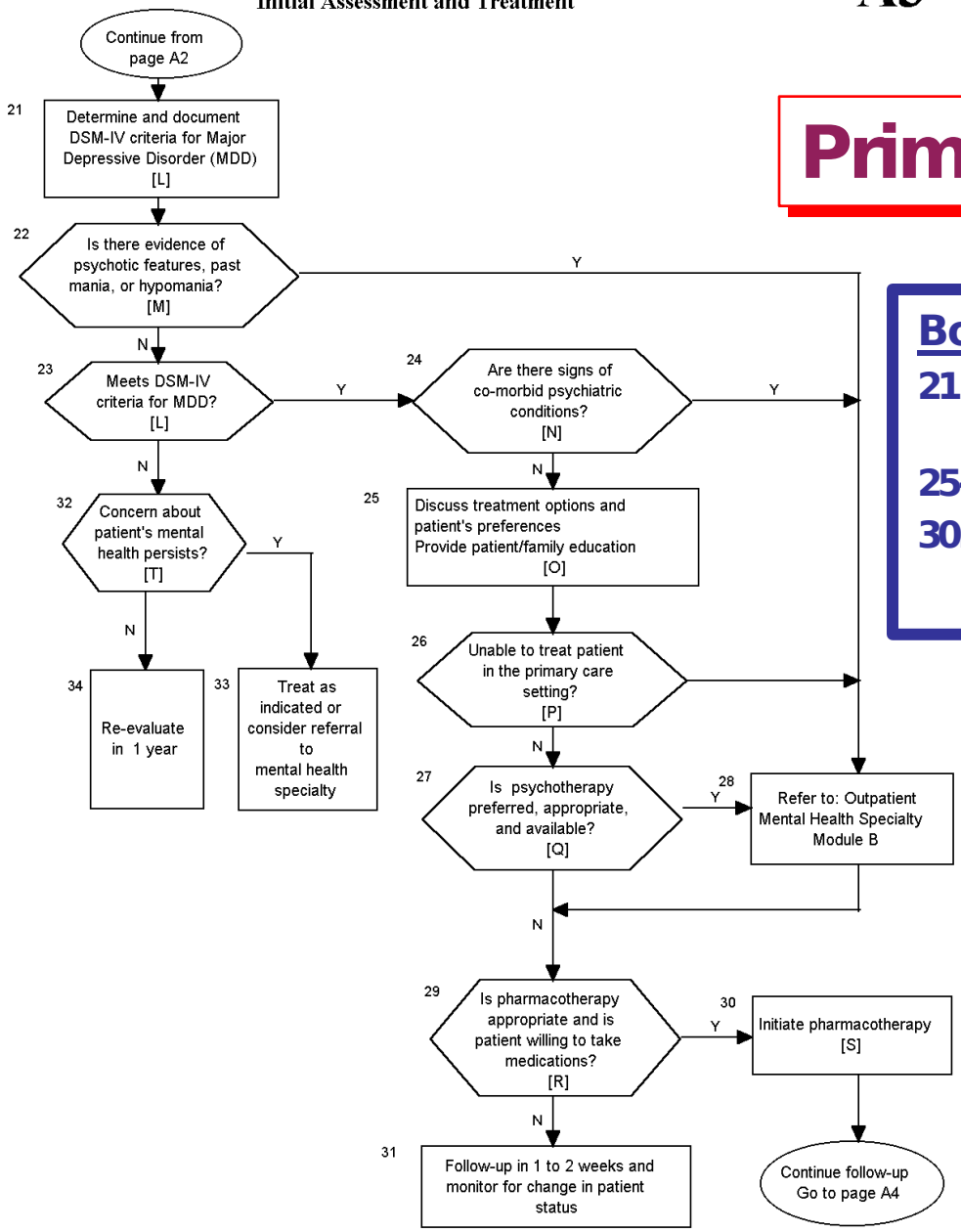



| Boxes | Strategy |
|---|---|
| 1. | Screening |
| 2 - 4. | Emergencies |
| 5. | General assessment |
| 6. | Depression symptoms? |




# Primary Care Module

| Boxes | Strategy |
|---|---|
| 12. | Danger |
| 13. | Psychosis |
| 14, 17. | Alternative causes - substances, physical illness, meds |
| 21 – 24. | Psychiatric causes – mania, MDD, comorbidities |

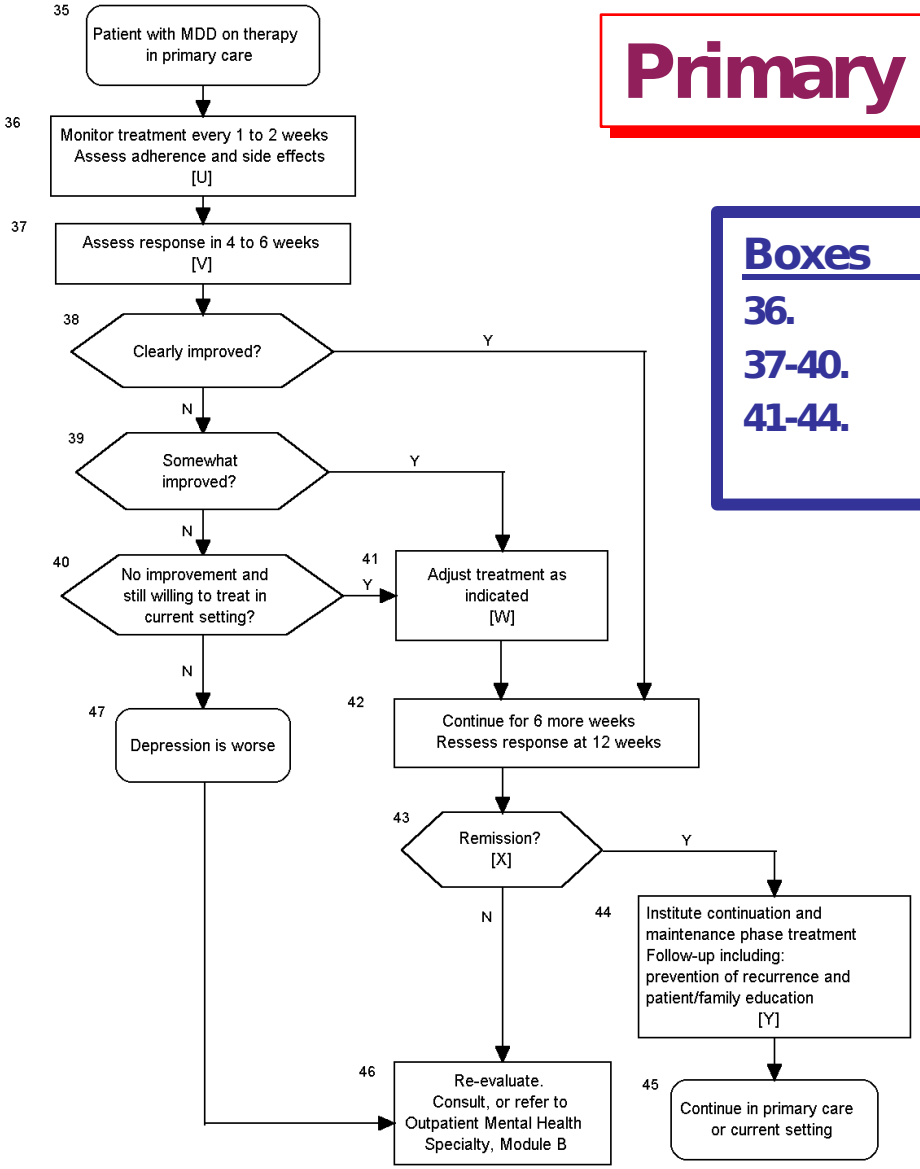



# Primary Care Module

| Boxes | Strategy |
|---|---|
| 21 – 24. | Psychiatric causes – mania, MDD, comorbidities |
| 25-29. | Review options, triage |
| 30. | Initiate pharmacotherapy |

Management of Major Depressive Disorder in Adults
in the Primary Care Setting
Follow-up Treatment

A4




# Primary Care Module

| Boxes | Strategy |
|---|---|
| 36. | Follow-up Q 1-2 weeks |
| 37-40. | Reassess at 4-6 weeks |
| 41-44. | Adjust, 12 week reassess |

# Tools:
# Primary Care Provider Info

- Algorithms
- Depression Red Flags (urgent risk factors)
- Cage-Aid (comorbid alcohol assessment)
- SIG-E-CAPS (depression symptom assessment)
- Suicide & violence assessment
- Diagnostic criteria (MDD & Dysthymia)
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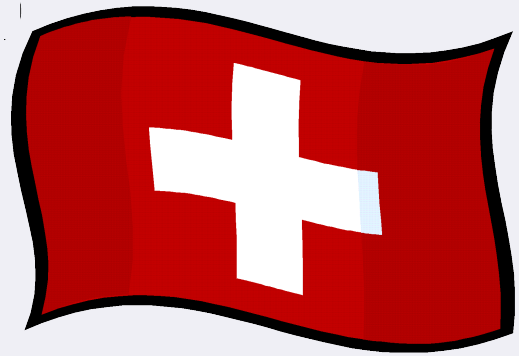
- Antidepressant table

# Red Flags



- Does patient need emergency treatment?
  - Suicidal or violent thoughts
  - Inability to care for self
  - Psychosis or mania
  - Unstable medical illness
  - Delirium
- Is active chemical abuse or dependency present?
- Is there a history of noncompliance or abuse of medications?
- Is there a strong suggestion of a personality disorder?

# Tools:
# Depression Care Forms

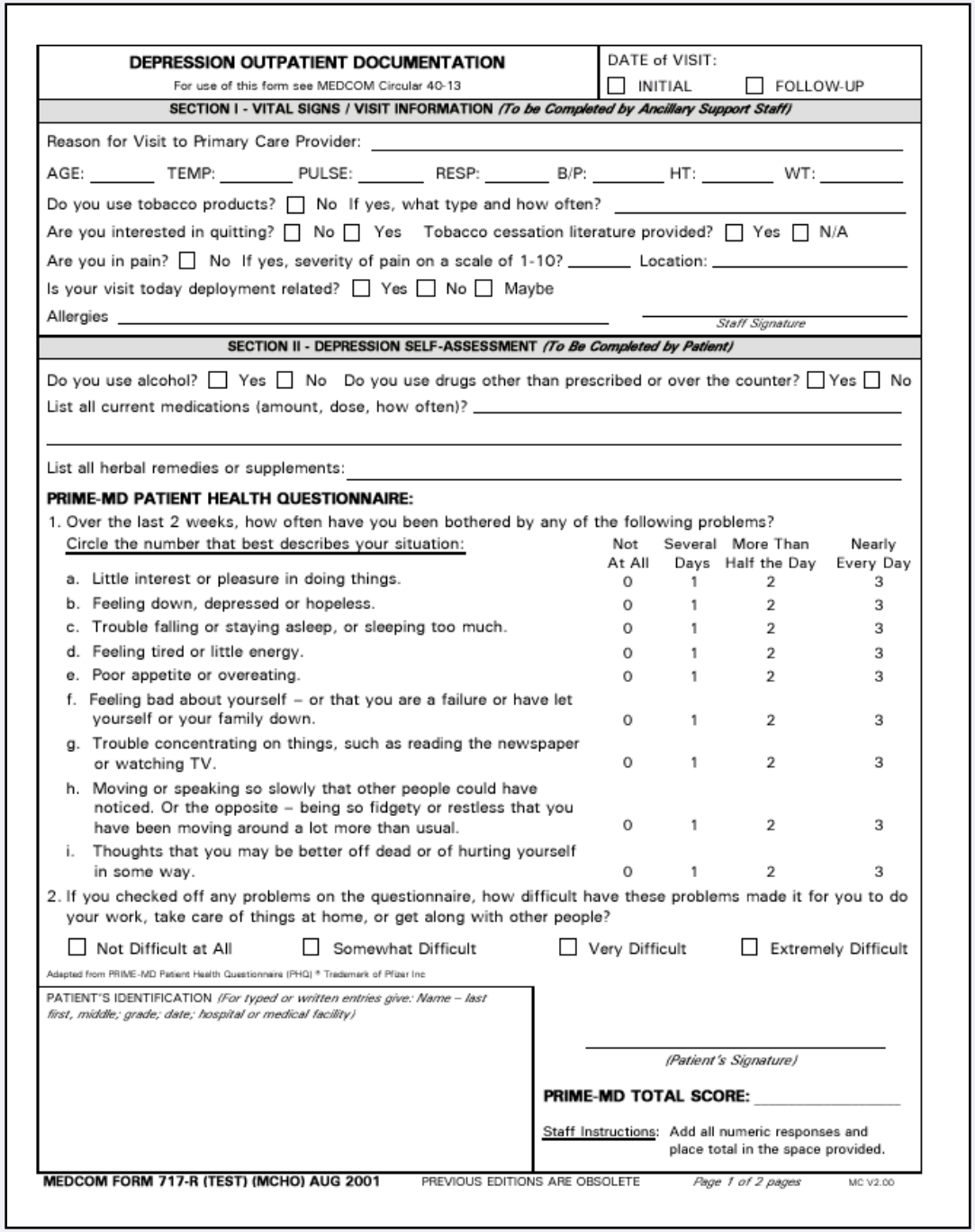
- Patient Self-Assessment (Prime-MD PHQ)
- Primary Care Provider Assessment
- Primary Care Referral
- Mental Health Feedback

# Form 717-R

# Page 1 of 2

# Depression Self-Assessment

1. Meds & OTC
2. Alcohol
3. Prime-MD PHQ



**DEPRESSION OUTPATIENT DOCUMENTATION**

For use of this form see MEDCOM Circular 40-13

DATE of VISIT: ☐ INITIAL ☐ FOLLOW-UP

**SECTION I - VITAL SIGNS / VISIT INFORMATION** *(To be Completed by Ancillary Support Staff)*

Reason for Visit to Primary Care Provider: _____

AGE: _____ TEMP: _____ PULSE: _____ RESP: _____ B/P: _____ HT: _____ WT: _____

Do you use tobacco products? ☐ No If yes, what type and how often? _____

Are you interested in quitting? ☐ No ☐ Yes Tobacco cessation literature provided? ☐ Yes ☐ N/A

Are you in pain? ☐ No If yes, severity of pain on a scale of 1-10? _____ Location: _____

Is your visit today deployment related? ☐ Yes ☐ No ☐ Maybe

Allergies _____ _____ *Staff Signature*

**SECTION II - DEPRESSION SELF-ASSESSMENT** *(To Be Completed by Patient)*

Do you use alcohol? ☐ Yes ☐ No Do you use drugs other than prescribed or over the counter? ☐ Yes ☐ No

List all current medications (amount, dose, how often)? _____

List all herbal remedies or supplements: _____

**PRIME-MD PATIENT HEALTH QUESTIONNAIRE:**

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

| Circle the number that best describes your situation: | Not At All | Several Days | More Than Half the Day | Nearly Every Day |
|---|---|---|---|---|
| a. Little interest or pleasure in doing things. | 0 | 1 | 2 | 3 |
| b. Feeling down, depressed or hopeless. | 0 | 1 | 2 | 3 |
| c. Trouble falling or staying asleep, or sleeping too much. | 0 | 1 | 2 | 3 |
| d. Feeling tired or little energy. | 0 | 1 | 2 | 3 |
| e. Poor appetite or overeating. | 0 | 1 | 2 | 3 |
| f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down. | 0 | 1 | 2 | 3 |
| g. Trouble concentrating on things, such as reading the newspaper or watching TV. | 0 | 1 | 2 | 3 |
| h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual. | 0 | 1 | 2 | 3 |
| i. Thoughts that you may be better off dead or of hurting yourself in some way. | 0 | 1 | 2 | 3 |

2. If you checked off any problems on the questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not Difficult at All ☐ Somewhat Difficult ☐ Very Difficult ☐ Extremely Difficult

Adapted from PRIME-MD Patient Health Questionnaire (PHQ) ® Trademark of Pfizer Inc

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name – last first, middle; grade; date; hospital or medical facility)*

_____ *(Patient's Signature)*

**PRIME-MD TOTAL SCORE:** _____

Staff Instructions: Add all numeric responses and place total in the space provided.

**MEDCOM FORM 717-R (TEST) (MCHO) AUG 2001** PREVIOUS EDITIONS ARE OBSOLETE *Page 1 of 2 pages* MC V2.00

**SECTION III – MEDICAL ASSESSMENT / DIAGNOSIS / TREATMENT PLAN / EDUCATION** *(To be completed by Provider)*

**PART A – MEDICAL HISTORY / PHYSICAL ASSESSMENT**

(Include a brief medical history, personal and family history, treatment of mental illness, possible organic causes of depression, physical findings, etc)

PRIME-MD SCORE:_____ CAGE SCORE:_____

**PART B – MENTAL STATUS ASSESSMENT**

| Document as indicated, or ☑ if N/A | | Examples |
|---|---|---|
| APPEARANCE: | ☐ | (appearance to age, dress, hygiene, grooming) |
| SPEECH: | ☐ | (volume, rate, clarity) |
| MOOD / AFFECT: | ☐ | (euthymic, anxious, flat, tearful, blunted, etc) |
| SENSORIUM: | ☐ | (time, person, place, situation) |
| THOUGHT COHERENCE: | ☐ | (logical, goal directed, tangential, loose associations) |
| DELUSIONS / HALLUCINATIONS: | ☐ | (paranoid, grandiose) / (auditory, visual, tactile) |
| HYPERACTIVITY: | ☐ | (excitable, little or no sleep, spending sprees, talkative) |
| RECENT STRESSORS: | ☐ | (death, birth, divorce, finances, unemployment, illness) |
| SUICIDE: | ☐ | (ideation, intent w plan, means, pt/family history of) |
| HOMICIDE: | ☐ | (ideation, intent w plan, means, past history of violence) |
| RESPONSE to INTERVIEW: | ☐ | (cooperative, frightened, distrustful, hostile, etc) |

**PART C – DIAGNOSIS / RISK FACTORS**

**RED FLAG RISK FACTORS: Check All That Apply:** ☐ Danger to Self ☐ Danger to Others

☐ Psychosis ☐ Delirium ☐ Personality D/O ☐ Substance Abuse ☐ Manic Symptoms

☐ Other mental disorder causing significant impairment of social, familial, vocational or educational functioning

**DSM-IV DIAGNOSIS:** ☐ Deferred ☐ Major Depressive D/O ☐ Depressive D/O NOS

☐ Mood D/O due to: _____ ☐ Mood D/O NOS ☐ Dysthymic D/O

Indicate the General Medical Condition

☐ Adjustment D/O with Depressed Mood ☐ Other: _____

**PART D – TREATMENT PLAN**

1. MEDICATION: _____
2. MONITORING PLAN: _____
3. REFERRAL: ☐ Self Care ☐ Nutrition ☐ Tobacco Cessation ☐ Pastoral ☐ Substance Abuse Program ☐ Behavioral Health Clinic ☐ Case Mgt Services ☐ Other: _____
4. CLINIC FOLLOW-UP: ☐ None ☐ 48/72 Hours ☐ One Week ☐ Two Weeks ☐ Other: _____
5. INSTRUCTIONS: _____

REVIEWED with PT: ☐ Yes ☐ No RESPONSE to PLAN: _____

**PART E – PATIENT / FAMILY EDUCATION / INSTRUCTIONS**

1. MEDICATION: ☐ Instruction/Precautions ☐ Literature ☐ Other: _____
2. DISEASE MANAGEMENT: ☐ Depression Brochure ☐ Depression Video ☐ Self-Mgt Guidelines Folder ☐ Tobacco Cessation Literature ☐ Safety Plan ☐ Other: _____
3. CONTINUITY of CARE: ☐ PCM F/U Appointment Info ☐ Activity ☐ Diet ☐ Referral Appointment
4. Other: _____

_____
*Primary Care Manager Signature / Date*



# Form 717-R

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# Depression Clinician Assessment

1. Medical Hx
2. Structured MS & E
3. Diagnosis
4. Red Flag Risk Factors
5. Interdisciplinary Treatment Plan
6. Patient & Family

# Form 723-R
## Page 1 of 2

## *Primary Care Referral to Mental Health*

1. Referral Reason
2. Med Problems
3. Depression assessment
4. Structured MSE
5. Current therapies

**BEHAVIORAL HEALTH REFERRAL / RESPONSE DOCUMENTATION**
For use of this form see MEDCOM Circular xxx

**DATE OF REQUEST**

**SECTION I - PRIMARY CARE CLINIC REFERRAL to BEHAVIORAL HEALTH**

**PART A - REASON for REFERRAL**

**Evaluation and Treatment:** (Check all that apply)

- ☐ Medication
- ☐ Psychological Testing
- ☐ Psychotherapy
- ☐ Group Therapy
- ☐ Family Therapy
- ☐ Marital Counseling
- ☐ Other: _____

**Advice for Treatment:** (Check all that apply)

- ☐ Capacity for Management in the Primary Care Setting
- ☐ Initial Medication Recommendation
- ☐ Medication Failure
- ☐ Side Effects from Current Medication
- ☐ Life-style Modification Plan
- ☐ Resource Identification
- ☐ Other: _____

**PART B - MEDICAL PROBLEMS and DEPRESSION ASSESSMENT**

**Relevant Medical Findings:**

Allergies: _____ Support System: _____

**Depression Assessment:** (Check all that apply)

- ☐ Feeling Down, Empty, Hopeless
- ☐ Loss of Interest or Pleasure
- ☐ Worthlessness, Guilt
- ☐ Poor Concentration
- ☐ Poor Energy
- ☐ Anxiety
- ☐ Sleep Disturbance (___ hrs/night)
- ☐ Decreased Appetite
- ☐ Increased Appetite
- ☐ Danger to Self/Others
- ☐ Drug Misuse/Abuse
- ☐ Periods of Hyperactivity/Excitability
- ☐ Weight Loss (___lbs in ___ weeks)
- ☐ Weight Gain (___lbs in ___ weeks)
- ☐ Past Use of Psychotropic Medication
- ☐ Past History of Depression
- ☐ Past Psychiatric Hospitalization
- ☐ Other: _____

**Diagnosis:** _____ **PRIME-MD SCORE:** _____ **CAGE-AID SCORE:** _____

**PART C - MENTAL STATUS ASSESSMENT**

| | Document as indicated, or ☑ if N/A | Examples |
|---|---|---|
| Appearance: | ☐ | (appearance to age, dress, hygiene, grooming) |
| Speech: | ☐ | (volume, rate, clarity) |
| Response to Interview: | ☐ | (cooperative, frightened, distrustful, hostile, etc) |
| Mood / Affect: | ☐ | (euthymic, anxious, flat, tearful, blunted, etc) |
| Sensorium: | ☐ | (time, person, place, situation) |
| Thought Coherence: | ☐ | (logical, goal directed, tangential, loose associations) |
| Delusions / Hallucinations: | ☐ | (paranoid, grandiose) / (auditory, visual, tactile) |
| Suicide / Homicide: | ☐ | (ideation, intent w plan, means, pt/family history) |
| Intelligence: | ☐ | (below average, average, above average) |

**PART D - CURRENT MEDICAL TREATMENT**

All Current Medications/Herbals/Supplements (amount & dose): _____

Current Interventions: _____

Other: _____

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

_____
*Signature of Primary Care Manager / Date*

Clinic: _____

Telephone: _____

**BEHAVIORAL HEALTH REFERRAL / RESPONSE DOCUMENTATION**
For use of this form see MEDCOM Circular xxx

**TO: PRIMARY CARE CLINIC**
**PCM:**

**DATE OF CONSULT**

**SECTION II - BEHAVIORAL HEALTH RESPONSE**

**PART A - DIAGNOSTIC IMPRESSION**

**PART B - TREATMENT PLAN**

**MEDICATION:** (Check and describe all that apply)

☐ Antidepressant Medications:

☐ Other Medications:

**INTERVENTION:** (Check and describe all that apply)

☐ Psychological Testing
☐ Cognitive Behavioral Therapy
☐ Interpersonal Psychotherapy
☐ Brief Dynamic Psychotherapy
☐ Group Therapy
☐ Family Therapy
☐ Marital Counseling
☐ Other: _____

Frequency:

Anticipated Length of Treatment:

**PART C - PATIENT EDUCATION**

Patient Response to Plan: _____

Medication Information: _____ Disease Management Information: _____

Appointment Schedule: _____ Other: _____

**PART D - CONTINUATION of CARE RECOMMENDATIONS**

**RECOMMENDATIONS TO PCM:**

PCM Clinic Follow-up Appointments: _____

Indications for Referral Back to Behavioral Health: _____

Medication Adjustment: _____

Laboratory Studies: _____ Other: _____

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*

_____
*Signature of Behavioral Health Specialist / Date*

Clinic: _____

Telephone: _____

**NOTE: At Conclusion or Discontinuation of Therapy Please Notify the Patient's PCM.**



# Form 723-R
## Page 2 of 2

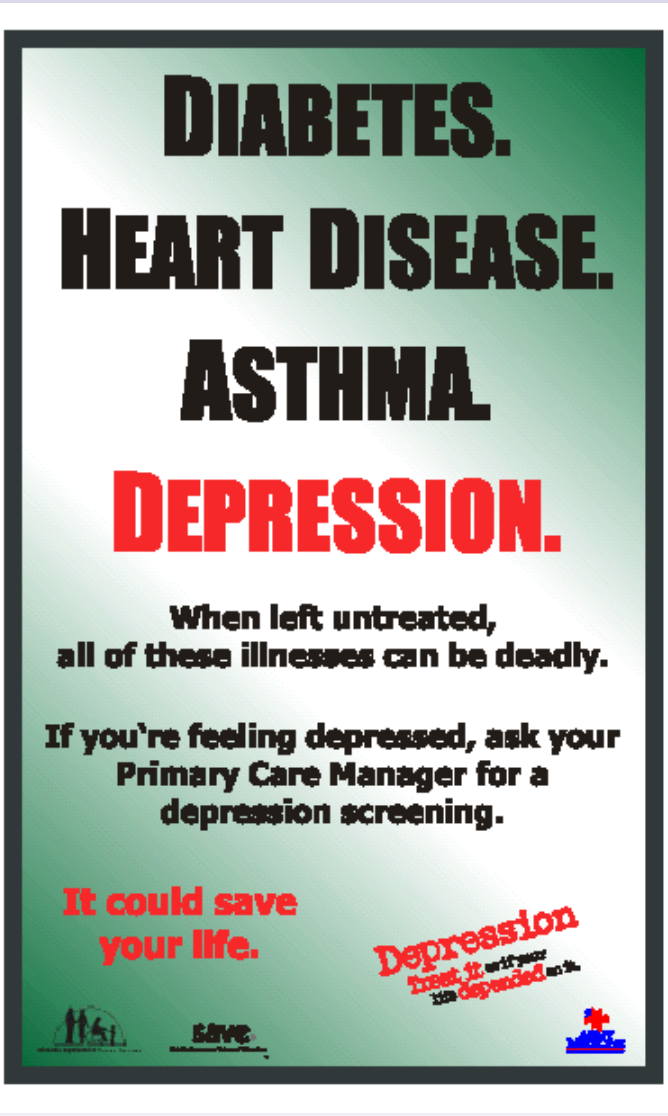
## *Mental Health Provider Response*

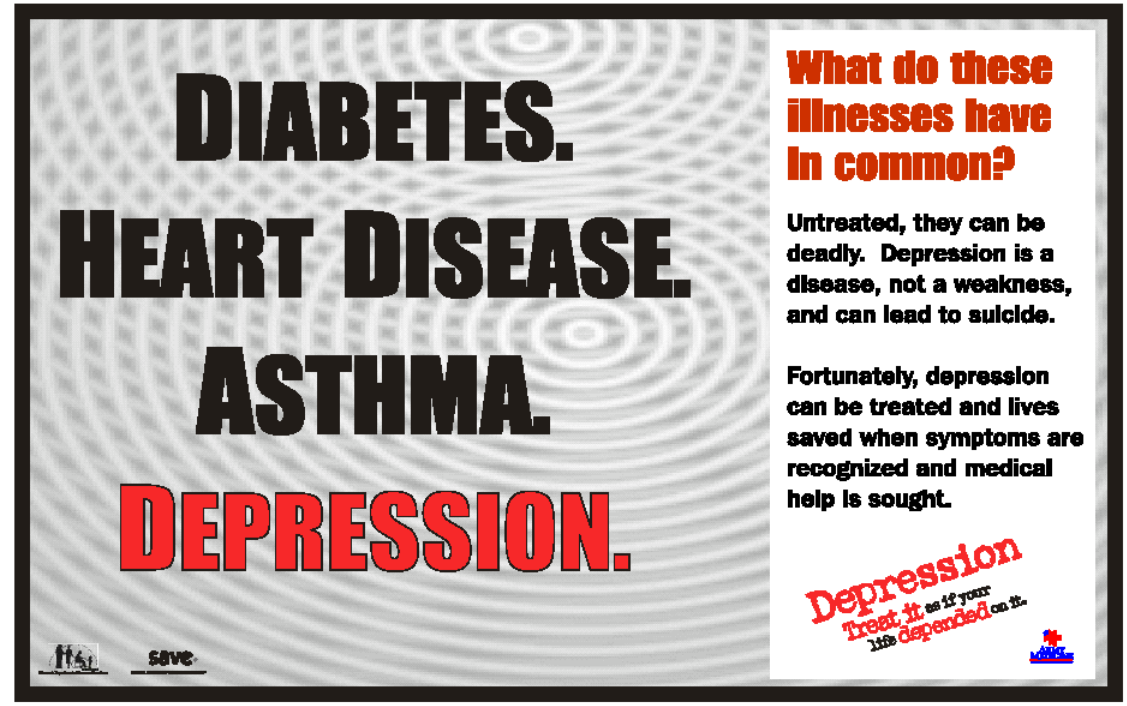
1. Diagnostic impression
2. Recommended meds
3. Recommended therapies
4. Patient education
5. Primary care recommendations

# Tools:
# Patient Education Materials

- Clinic posters
- Depression videotapes
- Self-management brochure
- Patient & family information brochure

# Patient Posters



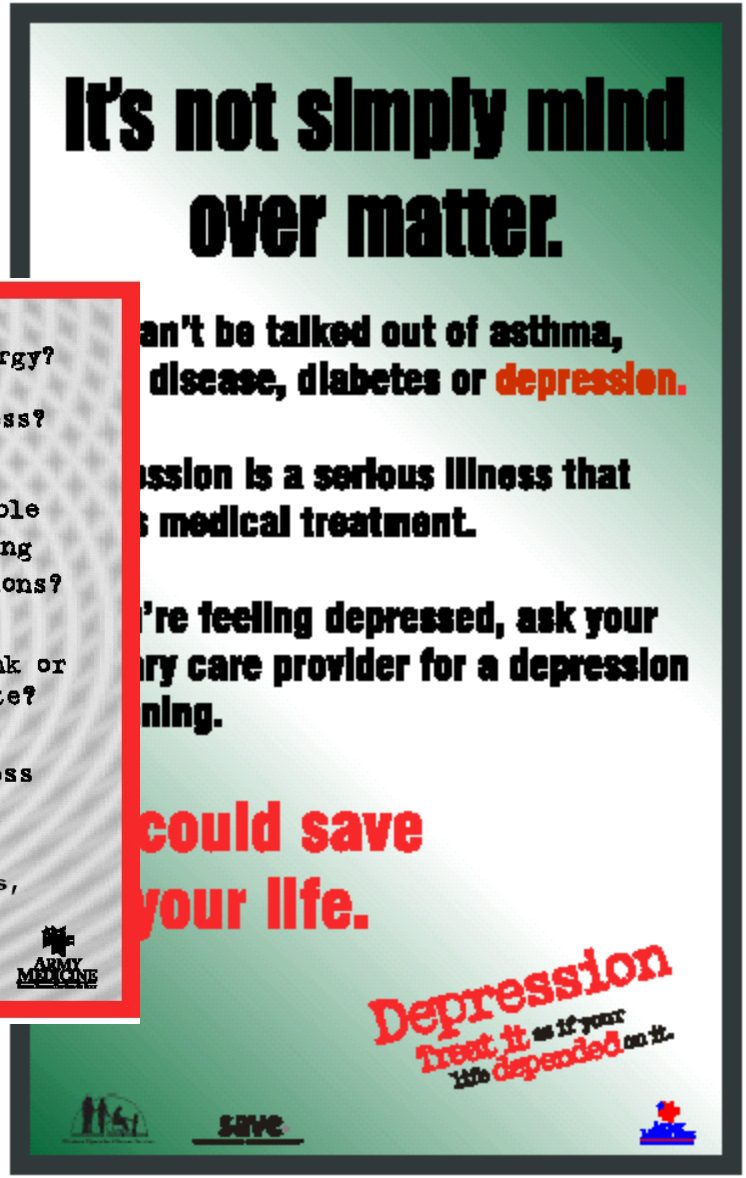
# Patient Posters

"Just snap out of it"
Snapping out of depression is as likely as talking yourself out of a heart attack. Depression is a serious illness that needs medical attention. Left untreated, depression can lead to suicide.
Fortunately, depression can be treated and lives saved when symptoms are recognized.
Some Symptoms Include:
Little Interest or Pleasure in Activities
Hard to Think or Concentrate
Feeling Worthless
Trouble Making Decisions
Feeling Restless or Nervous
Changes in Eating and/or Sleeping Patterns
Fatigue or No Energy
Thoughts of Death or Suicide
If you or someone you know has these symptoms for more than two weeks, ask your primary care provider for a depression screening.
Depression
Treat it as if your life depended on it.

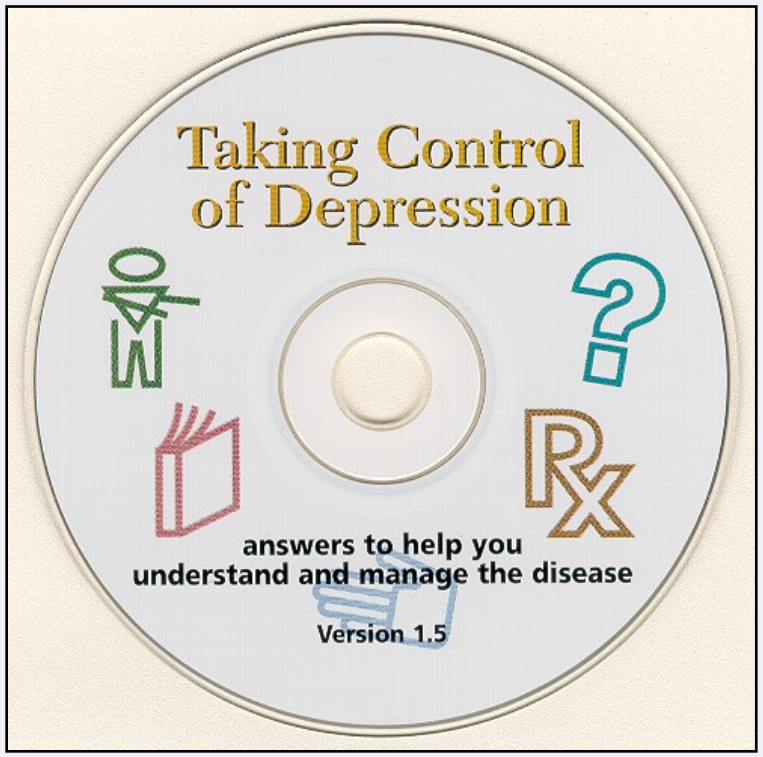
Sometimes, it's not just a bad day.
Everyone has a bad day now and then. When that bad day lasts for weeks, it's time to see your primary care provider.
Like asthma, heart disease, or diabetes, depression can be a serious illness.
Left untreated, it can lead to suicide.
Depression
Treat it as if your life depended on it.

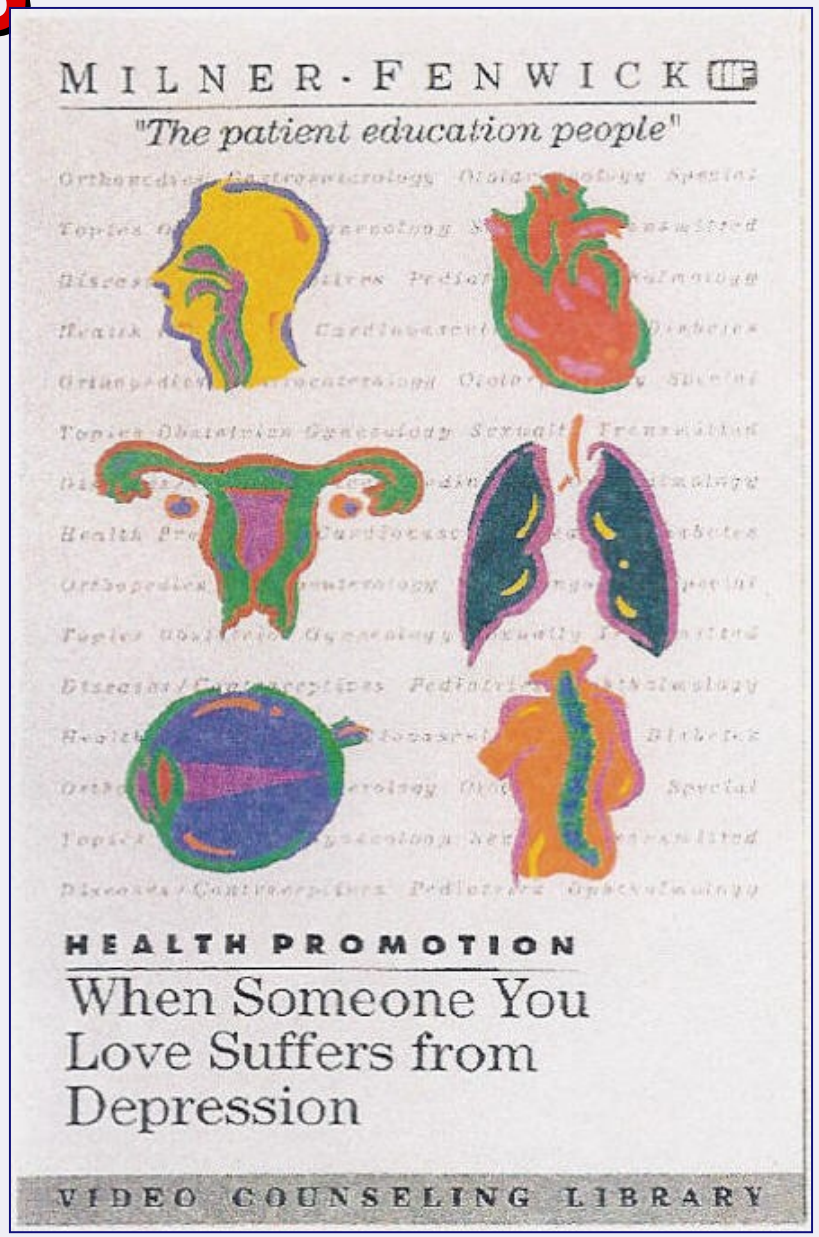
# Patient Posters

Little Interest or Pleasure in Activities?
Thoughts of Suicide?
Fatigue or No Energy?
Feeling Worthless?
Too Little or Too Much Sleep?
Depression
Treat it as if your life depended on it.
Trouble Making Decisions?
Recent Weight Loss or Gain?
Hard to Think or Concentrate?
Feeling Bad About Yourself?
Thoughts of Death?
Feeling Restless or Nervous?
If You Are Experiencing Any of These Symptoms, Talk To Your Primary Care Manager.
save
ARMY MEDICINE



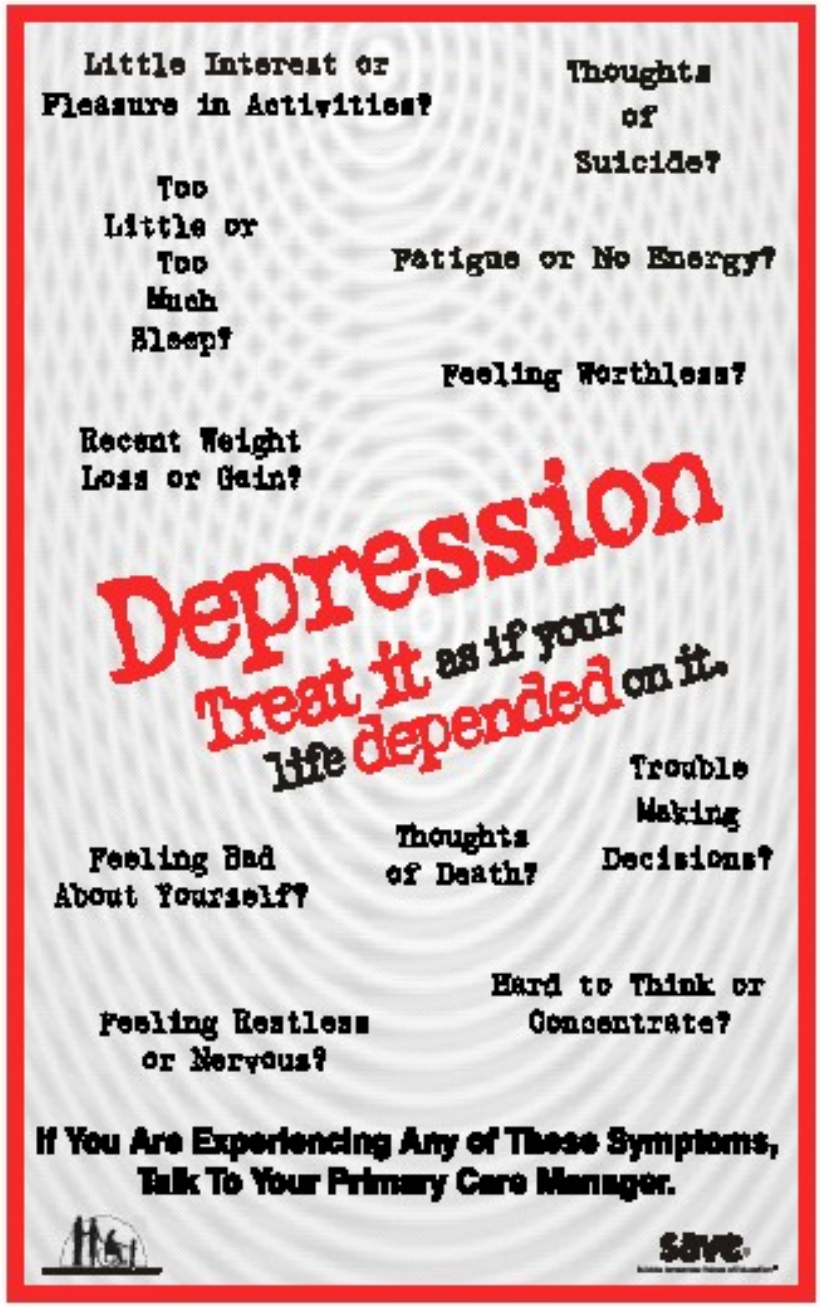
# Depression Video and CD-ROM



# Patient & Family Education Brochure

Available in Spanish


Little Interest or Pleasure in Activities?
Thoughts of Suicide?
Too Little or Too Much Sleep?
Fatigue or No Energy?
Feeling Worthless?
Recent Weight Loss or Gain?
Depression
Treat it as if your life depended on it.
Trouble Making Decisions?
Thoughts of Death?
Feeling Bad About Yourself?
Hard to Think or Concentrate?
Feeling Restless or Nervous?
If You Are Experiencing Any of These Symptoms, Talk To Your Primary Care Manager.
save.

## WHAT YOU and YOUR FAMILY SHOULD KNOW ABOUT DEPRESSION

- **What is Major Depression? -** A medical illness, characterized by depression that is believed due to biochemical changes in brain function.
- **Myths -** Major depression is not a trivial disorder, will not go away on its own and is not the result of personal weakness, laziness or lack of will power.
- **Incidence -** Depression is one of the most common illnesses treated by health care professionals, affecting one out of every 20 people sometime in their lifetime.
- **Risk Factors -** Females, people with a first degree relative with depression, people with a history of drug or alcohol abuse or people with a history of anxiety or eating disorders have an increased incidence of depression.
- **Treatment Response -** Depression is very responsive to treatment through antidepressant medication, psychotherapy or a combination. People do get better.
- **Medications -** All antidepressant medications take several weeks to produce their full effect.
- **Medication Safety -** Antidepressants are safe when taken as prescribed and are not addicting.
- **Medication Side Effects -** Discuss medication side effects or other problems with your primary care manager. Most problems can be resolved.
- **Don't -** Drink alcohol, self-medicate, blame yourself or make major life decisions or changes during treatment.
- **Do -** Get plenty of rest, exercise, eat regularly, socialize.
- **Outpatient vs Inpatient Care -** Most depressions are successfully treated in the primary care manager's office. Inpatient hospitalization is generally reserved for patients who have delusions or hallucinations or are a danger to themselves or others.
- **Consultation/Referral -** Sometimes a second opinion is required because a combination of treatments might work best, or the depression is severe or lasts a long time or the first treatment did not work well.
- **Treatment Compliance -** Medication must be taken as directed, including dosage, frequency and length of time prescribed. Follow-up appointments with your primary care manager, mental health specialist or others need to be kept as scheduled.
- **Suicide -** Thoughts of death often accompany depression. Always discuss this symptom with your primary care provider. If your provider is not available, tell a trusted friend or relative who can get you immediate emergency professional help.
- **Communication -** Ask questions about treatment. Verbalize any concerns. Discuss with your primary care manager your feelings, activity, sleep and eating patterns, as well as unusual symptoms or physical problems.
- **Recurrence -** Depression is often recurrent. Maintenance antidepressants are sometimes indicated.

VA/DoD Depression Clinical Practice Guideline
April 2002

# Self-Management

## A Guide for Patients

Depression
Treat it as if your life depended on it.

save.

**Complete a new booklet before each appointment. Review with your Primary Care Manager.**

Date/Time of Today's Appointment: _____ Date/Time of Last Appointment: _____

My Primary Care Manager is: _____ at the _____ Clinic

Telephone: _____ Date/Time of Next Appointment: _____

**Since my last visit with my Primary Care Manager I have had the following symptoms:** (Check all that apply)

| | | | |
|---|---|---|---|
| ☐ Depressed Mood | ☐ Feelings of Guilt | ☐ Weight Loss | ☐ Insomnia |
| ☐ Little Interest/Pleasure | ☐ Crying Spells | ☐ Weight Gain | ☐ Sleeping Too Much |
| ☐ Feelings of Worthlessness | ☐ Indecisiveness | ☐ Hopelessness | ☐ Homicidal Ideation |
| ☐ Fatigue/Loss of Energy | ☐ Poor Concentration | ☐ Suicidal Ideas | ☐ Suicidal Plans |

☐ Other Symptoms: _____

**Health Care Concerns:** I want to discuss the following concerns with my Primary Care Manager:

_____

_____

**Medication Information:**

My antidepressant medication is: _____ _____ mg, taken at these times: _____

Side Effects I am experiencing are: _____

_____

Other medications I am taking: _____

**Educational Resources:** I will read or view the following to help me learn more about depression:

☐ CD-ROM "Taking Control of Depression" ☐ VA/DoD Depression Brochure ☐ Other: _____

☐ Medication Information Handout ☐ Depression Video ☐ Other: _____

**Referral Services:** I will keep the following appointments, if scheduled. Write in appointment date and time.

☐ Behavioral Health: _____ ☐ Chaplain/Minister: _____

☐ Case Management Services: _____ ☐ Substance Abuse Program: _____

Other Referral: _____

**Supportive Family or Friends:** Fill in Name and Telephone Number:

Name: _____ Phone: _____ Name: _____ Phone: _____

**Emergency Contacts:** Fill in Telephone Number:

☐ Emergency Dept: _____ ☐ Crisis Center: _____ ☐ Police/EMS: _____

I will contact a support friend or relative or call an emergency contact in the event I experience serious medication side effects, suicidal thoughts or plans or thoughts of harming others.

**Instructions from My Primary Care Manager:**

_____

_____

_____
Signature of Patient / Date

# Patient Self-Management Folder

# Tools:
# Primary Care Provider Info

- Algorithms
- Depression Red Flags (urgent risk factors)
- Cage-Aid (comorbid alcohol assessment)
- SIG-E-CAPS (depression symptom assessment)
- Suicide & violence assessment
- Diagnostic criteria (MDD & Dysthymia)
- Patient education guidance
- Admission & referral criteria
- Antidepressant Medication Table

# VA / DOD DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD
# ANTIDEPRESSANT MEDICATION TABLE

CARD A1

**Refer to pharmaceutical manufacturer's literature for full prescribing information**

## SEROTONIN SELECTIVE REUPTAKE INHIBITORS (SSRIs)

| GENERIC | BRAND NAME | ADULT STARTING DOSE | MAX | EXCEPTION | SAFETY MARGIN | TOLERABILITY | EFFICACY | SIMPLICITY |
|---|---|---|---|---|---|---|---|---|
| Citalopram | Celexa | 20 mg | 60 mg | Reduce dose for the elderly & those with renal or hepatic failure | No serious systemic toxicity even after substantial overdose. Drug interactions may include tricyclic antidepressants, carbamazepine & warfarin. | Nausea, insomnia, sedation, headache, fatigue dizziness, sexual dysfunction anorexia, weight loss, sweating, GI distress, tremor, restlessness, agitation, anxiety. | Response rate = 2 - 4 wks | AM daily dosing. Can be started at an effective dose immediately. |
| Fluoxetine | Prozac | 20 mg | 80 mg | | | | | |
| Paroxetine | Paxil | 20 mg | 50 mg | | | | | |
| Sertraline | Zoloft | 50 mg | 200 mg | | | | | |

**First Line Antidepressant Medication**

Drugs of this class differ substantially in safety, tolerability and simplicity when used in patients on other medications. Can work in TCA (tricyclic antidepressant) nonresponders. Useful in several anxiety disorders. Taper gradually when discontinuing these medications.

## SEROTONIN and NOREPINEPHRINE REUPTAKE INHIBITORS

| GENERIC | BRAND NAME | ADULT STARTING DOSE | MAX | EXCEPTION | SAFETY MARGIN | TOLERABILITY | EFFICACY | SIMPLICITY |
|---|---|---|---|---|---|---|---|---|
| Venlafaxine IR | Effexor IR | 75 mg | 375 mg | Reduce dose for the elderly & those with renal or hepatic failure | No serious systemic toxicity. Downtaper slowly to prevent clinically significant withdrawal syndrome. Few drug interactions. | Take with food. Comparable to SSRIs at low dose. Nausea, dry mouth, insomnia, anxiety, somnolence, headache, dizziness, asthenia, abnormal ejaculation, sweating. | Response rate = 2 - 4 wks (4 - 7 days at ~300 mg/day) | BID or TID dosing with IR. Daily dosing with XR. Can be started at an effective dose (75 mg) immediately. |
| Venlafaxine XR | Effexor XR | 75 mg | 375 mg | | | | | |

Dual action drug that predominantly acts like a Serotonin Selective Reuptake inhibitor at low doses and adds the effect of an Norepinephrine Selective Reuptake Inhibitor at high doses. Possible efficacy in cases not responsive to TCAs or SSRIs. Taper dose prior to discontinuation.

## DOPAMINE and NOREPINEPHRINE REUPTAKE INHIBITORS

| GENERIC | BRAND NAME | ADULT STARTING DOSE | MAX | EXCEPTION | SAFETY MARGIN | TOLERABILITY | EFFICACY | SIMPLICITY |
|---|---|---|---|---|---|---|---|---|
| Bupropion - IR | Wellbutrin - IR | 200 mg | 450 mg | Reduce dose for the elderly & those with renal or hepatic failure | Seizure risk at doses higher than max or with other drugs that increase seizure risk. Drug/drug interactions uncommon. | Rarely causes sexual dysfunction. | Response rate = 2 - 4 wks | BID or TID dosing. Increase dose gradually to decrease risk of seizures. Requires dose titration. |
| Bupropion - SR | Wellbutrin - SR | 150 mg | 400 mg | | | | | |

Least likely antidepressant to result in a patient becoming manic. Do not use if there is a history of seizure disorder, head trauma, bulimia or anorexia. Can work in TCA non-responders.

## NOREPINEPHRINE SELECTIVE REUPTAKE INHIBITORS

| GENERIC | BRAND NAME | ADULT STARTING DOSE | MAX | EXCEPTION | SAFETY MARGIN | TOLERABILITY | EFFICACY | SIMPLICITY |
|---|---|---|---|---|---|---|---|---|
| Desipramine * | Norpramin * | 75 - 200 mg | 300 mg | Reduce dose for the elderly & those with renal or hepatic failure | Serious toxicity can result from OD. Reserve Maprotiline as a second-line agent due to risk of seizures at therapeutic & nontherapeutic doses. | Generally Good. | Response rate = 2 - 4 wks<br>Therapeutic levels:<br>Desipramine 125-300 ng/mL<br>Nortriptyline 50-150 ng/mL | Can be given QD. Can start effective dose immediately. Monitor serum level after one week of treatment. |
| Nortriptyline * | Aventyl/Pamelor * | 50 mg | 150 mg | | | | | |
| Maprotiline ** | Ludiomil ** | 75 mg | 225 mg | | | | | |

Consider Desipramine or Nortriptyline first in the elderly if TCAs are necessary.

* **Secondary Amine Tricyclic Antidepressants (SATCAs)** ** **Tetracyclic Antidepressant**

# VA / DOD DEPRESSION PRACTICE GUIDELINE PROVIDER CARE CARD
# ANTIDEPRESSANT MEDICATION TABLE

CARD A 2

Refer to pharmaceutical manufacturer's literature for full prescribing information

## SEROTONIN (5-H2A) RECEPTOR ANTAGONIST and WEAK SEROTONIN REUPTAKE INHIBITORS

| GENERIC | BRAND NAME | ADULT STARTING DOSE | MAX | EXCEPTION | SAFETY MARGIN | TOLERABILITY | EFFICACY | SIMPLICITY |
|---|---|---|---|---|---|---|---|---|
| Nefazodone * | Serzone * | 200 mg | 600 mg | Reduce dose for the elderly & those with renal or hepatic failure | No serious systemic toxicity from OD. Can interact with agents that decrease arousal, impair cognitive performance and interact with adrenergic agents that regulate blood pressure. | Somnolence, dizziness, fatigue, dry mouth, nausea, headache, constipation, impaired vision. Unlikely to cause sexual dysfunction. | Response rate = 2 - 4 wks | BID dosing. Requires dose titration. |
| Trazodone | Desyrel | 150 mg | 600 mg | | | | | |

Corrects sleep disturbance and reduces anxiety in about one week.

* **Caution - Nefazodone Specific**- Monitor for signs & symptoms of liver dysfunction; consider LFT monitoring. Do not take with triazolam, alprazolam, pimozide, astemizole, cisapride & terfenadine due to increased plasma levels. If on Digoxin, monitor levels.

## MIXED REUPTAKE and NEURORECEPTOR ANTAGONISTS

| GENERIC | BRAND NAME | ADULT STARTING DOSE | MAX | EXCEPTION | SAFETY MARGIN | TOLERABILITY | EFFICACY | SIMPLICITY |
|---|---|---|---|---|---|---|---|---|
| Amitriptyline * | Elavil, Endep * | 50 - 100 mg | 300 mg | Reduce dose for those with renal or hepatic failure | Serious toxicity can result from OD. Slow system clearance. Can cause multiple drug/drug interactions. | Sedation, increased anticholinergic effects, orthostatic hypotension, cardiac conduction disturbances, arrhythmia & wt gain, dizziness, sexual dysfunction. | Response rate = 2 - 4 wks<br>Therapeutic Levels: Imipramine 200-350 ng/mL | Can be given QD. Monitor serum level after one week of treatment. |
| Imipramine * | Tofranil * | 75 mg | 300 mg | | | | | |
| Doxepin * | Sinequan * | 75 mg | 300 mg | | | | | |

**These antidepressants are not recommended for use in the elderly.**

Highest response rates. TATCAs useful in chronic pain, migraine headaches & insomnia.

* **Tertiary Amine Tricyclic Antidepressants (TATCAs).**

**CAUTION: In rare cases initiating or titrating routine antidepressant medication can precipitate a manic episode in some individuals.**

**CAUTION: if patient is currently receiving an MAOI consult/refer to a behavioral health physician for medication prescribing.**

**NOTE: Antidepressant Medication Information current as of February 2002. May become outdated.**

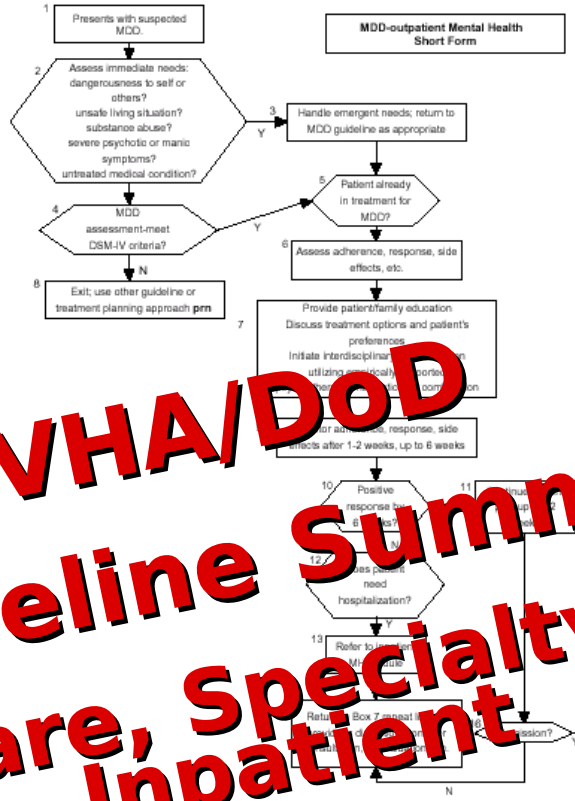
## MEDICATIONS THAT CAN CAUSE DEPRESSION

| QUALITY of EVIDENCE | STRENGTH of RECOMMENDATION | DRUG / DRUG CLASS |
|---|---|---|
| I | B | Amphetamine withdrawal, Anabolic Steroids, Digitalis, Glucocorticoids |
| I | C | Cocaine withdrawal |
| II-1 | C | Reserpine |
| II-2 | A | Gonadotropin-releasing agonists, Pimozide |
| II-2 | B | Propanolol (Beta Blockers) |
| II-2 | C | ACE Inhibitors, Antihyperlipidemics, Benzodiazepines, Cimetidine, Ranitidine, Clonidine, Cycloserine, Interferons, Levodopa, Methyldopa, Metoclopramide, Oral Contraceptives, Topiramate, Verapamil, (Calcium Channel Blockers) |

Although there is little published information on alternative medicines causing depression, consideration should also be given to herbal, nutritional, vitamins and body building supplements, particularly when consumed in large doses.

# VHA/DoD Clinical Practice Guideline
# Management of Major Depressive Disorder (MDD) in Adults in Outpatient Mental Health Specialty Setting

## Guideline Summary


MDD-outpatient Mental Health Short Form
1 Presents with suspected MDD.
2 Assess immediate needs: dangerousness to self or others? unsafe living situation? substance abuse? severe psychotic or manic symptoms? untreated medical condition?
3 Handle emergent needs; return to MDD guideline as appropriate
4 MDD assessment-meet DSM-IV criteria?
5 Patient already in treatment for MDD?
6 Assess adherence, response, side effects, etc.
7 Provide patient/family education
Discuss treatment options and patient's preferences
8 Exit; use other guideline or treatment planning approach prn
10 Positive response by
11
12 Does patient need hospitalization?
13
15 Initiate maintenance plan
Y
N

Sponsored & produced by the VA Employee Education System in cooperation with the Offices of Quality & Performance and Patient Care Services and DoD.

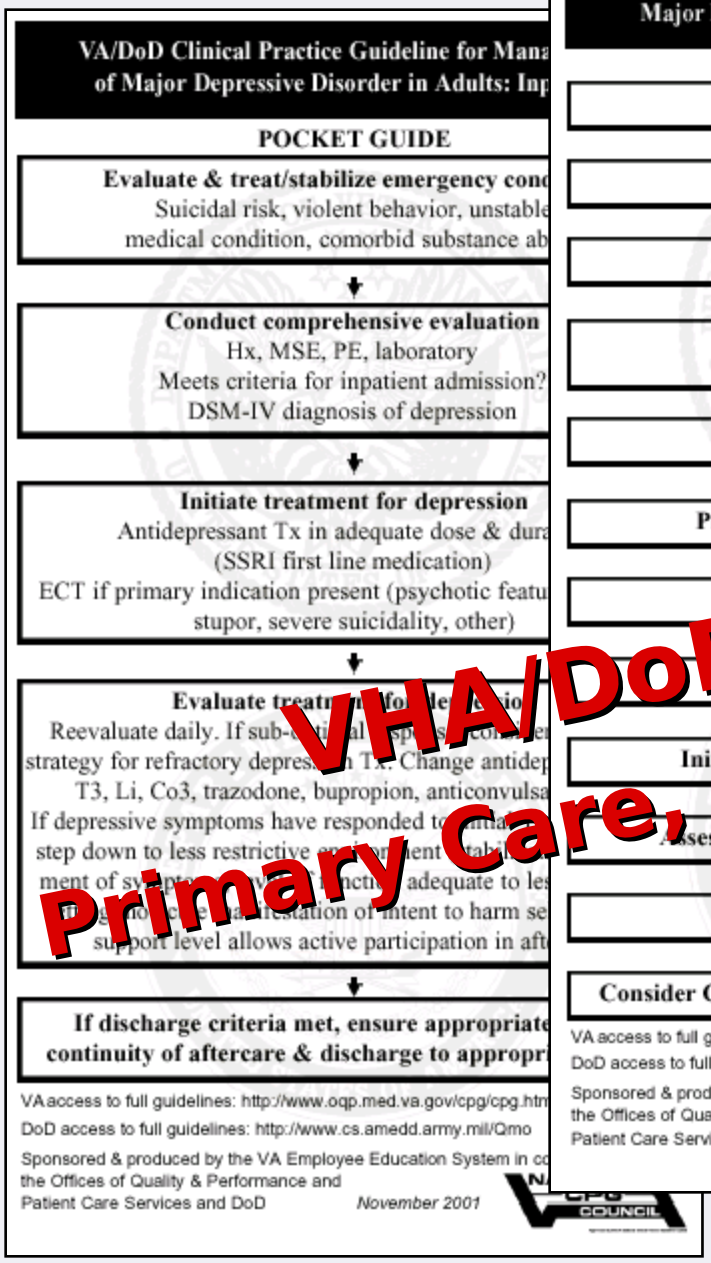
VA access for guidelines: http://www.ocp.med.va.gov/cpg/cpg.asp

DoD access for guidelines: http://www.cs.amedd.army.mil/Qmo

August 2001

NATIONAL CPG COUNCIL

VHA/DoD Guideline Summary Primary Care, Specialty Setting & Inpatient


VA/DoD Clinical Practice Guideline for Mana
of Major Depressive Disorder in Adults: Inp
POCKET GUIDE
Evaluate & treat/stabilize emergency cond
Suicidal risk, violent behavior, unstable
medical condition, comorbid substance ab
Conduct comprehensive evaluation
Hx, MSE, PE, laboratory
Meets criteria for inpatient admission?
DSM-IV diagnosis of depression
Initiate treatment for depression
Antidepressant Tx in adequate dose & dura
(SSRI first line medication)
ECT if primary indication present (psychotic featu
stupor, severe suicidality, other)
Evaluate treatm
Reevaluate daily. If sub-
strategy for refractory depres
T3, Li, Co3, trazodone, bupropion, anticonvulsa
If depressive symptoms have responded to
step down to less restrictive
ment of sy
adequate to les
support level allows active participation in aft
If discharge criteria met, ensure appropriate
continuity of aftercare & discharge to appropri
VA access to full guidelines: http://www.oqp.med.va.gov/cpg/cpg.htm
DoD access to full guidelines: http://www.cs.amedd.army.mil/Qmo
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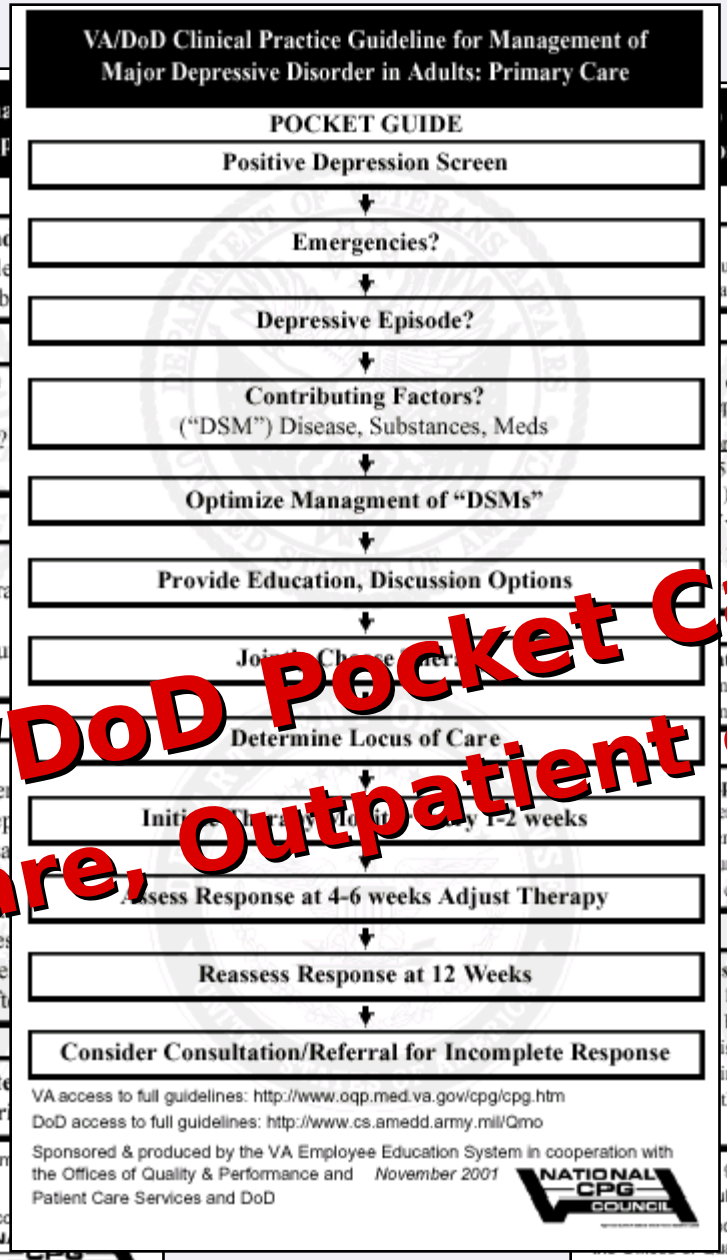
VA/DoD Clinical Practice Guideline for Management of
Major Depressive Disorder in Adults: Primary Care
POCKET GUIDE
Positive Depression Screen
Emergencies?
Depressive Episode?
Contributing Factors?
("DSM") Disease, Substances, Meds
Optimize Managment of "DSMs"
Provide Education, Discussion Options
Determine Locus of Care
Assess Response at 4-6 weeks Adjust Therapy
Reassess Response at 12 Weeks
Consider Consultation/Referral for Incomplete Response
VA access to full guidelines: http://www.oqp.med.va.gov/cpg/cpg.htm
DoD access to full guidelines: http://www.cs.amedd.army.mil/Qmo
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November 2001
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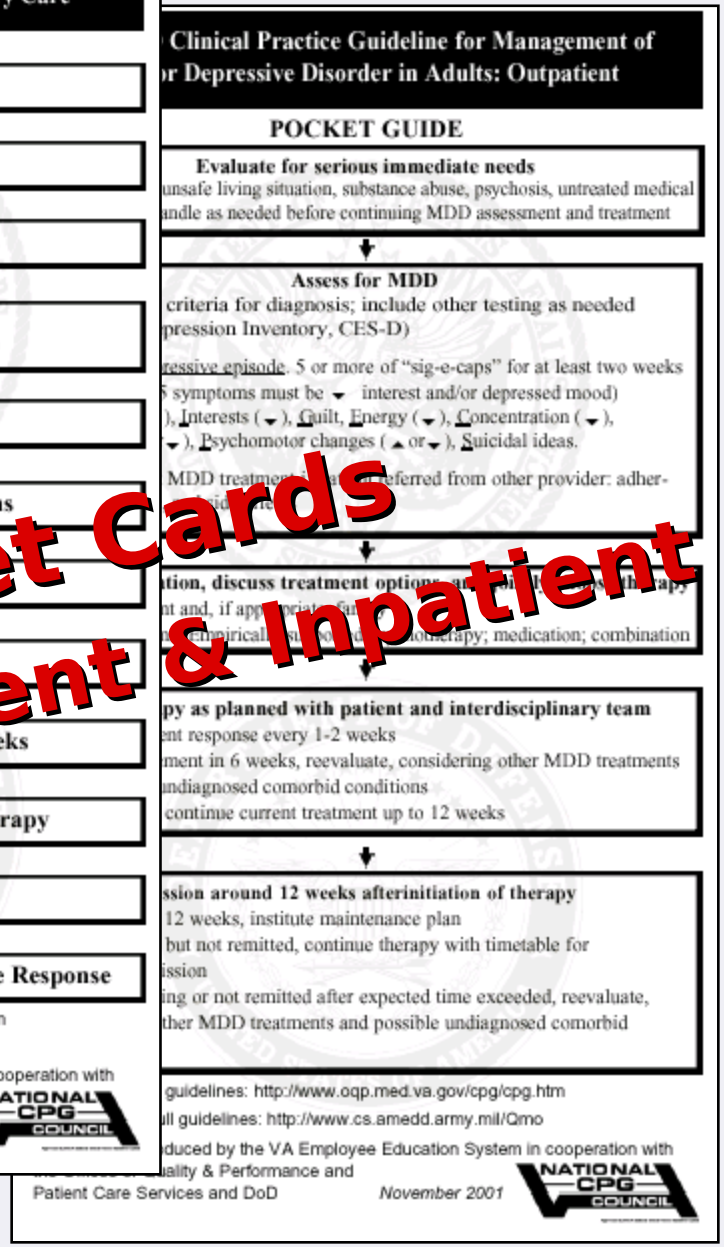
Clinical Practice Guideline for Management of
r Depressive Disorder in Adults: Outpatient
POCKET GUIDE
Evaluate for serious immediate needs
unsafe living situation, substance abuse, psychosis, untreated medical
andle as needed before continuing MDD assessment and treatment
Assess for MDD
criteria for diagnosis; include other testing as needed
pression Inventory, CES-D)
ressive episode. 5 or more of "sig-e-caps" for at least two weeks
symptoms must be interest and/or depressed mood)
), Interests ( ), Guilt, Energy ( ), Concentration ( ),
), Psychomotor changes ( or ), Suicidal ideas.
MDD treatment
eferred from other provider: adher-
tion, discuss treatment options
nt and, if appr
mpirical
otherapy; medication; combination
py as planned with patient and interdisciplinary team
nt response every 1-2 weeks
ment in 6 weeks, reevaluate, considering other MDD treatments
ndiagnosed comorbid conditions
continue current treatment up to 12 weeks
ssion around 12 weeks afterinitiation of therapy
12 weeks, institute maintenance plan
but not remitted, continue therapy with timetable for
ission
ing or not remitted after expected time exceeded, reevaluate,
ther MDD treatments and possible undiagnosed comorbid
guidelines: http://www.oqp.med.va.gov/cpg/cpg.htm
ll guidelines: http://www.cs.amedd.army.mil/Qmo
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ality & Performance and
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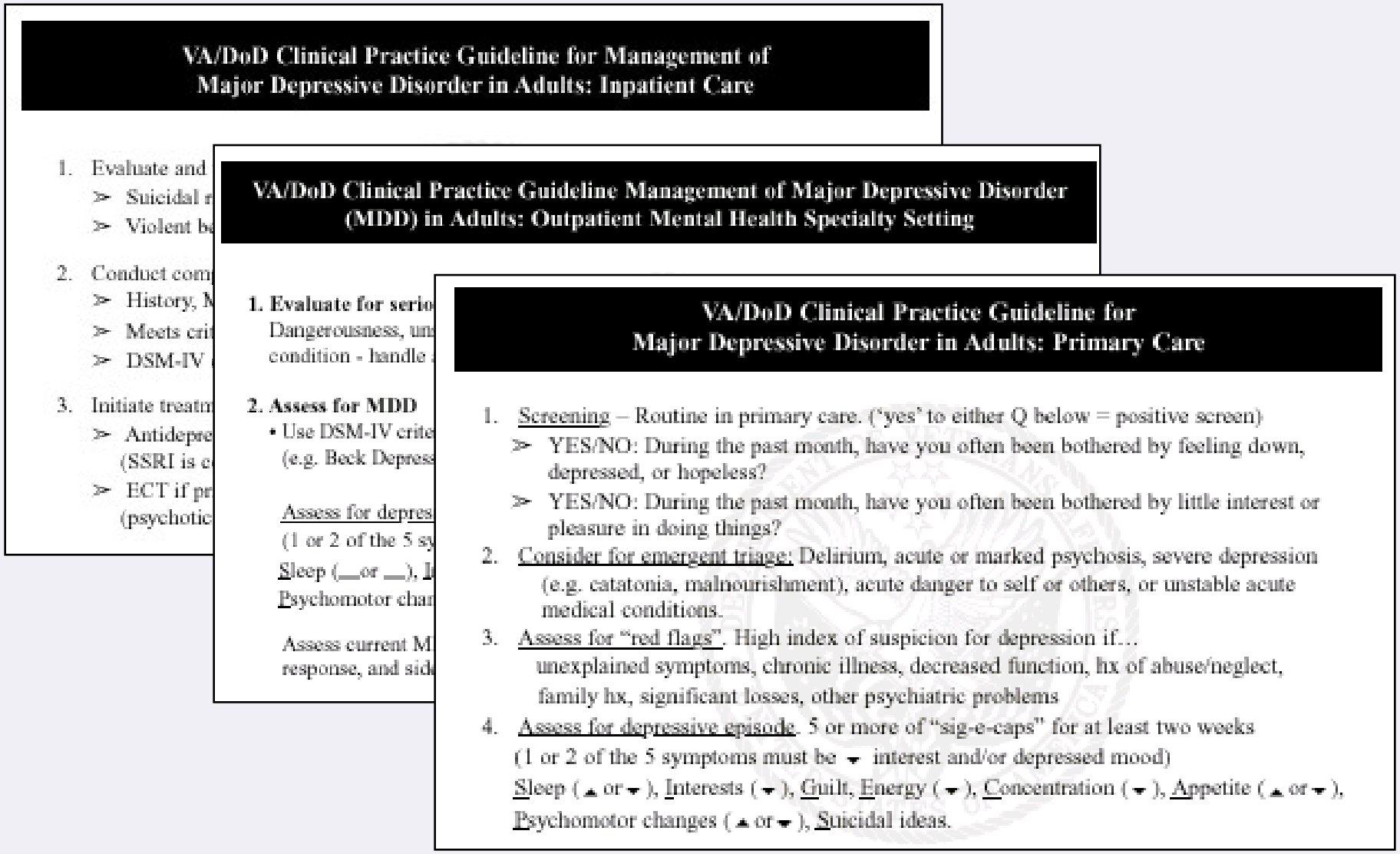
VHA/DoD Pocket Cards
Primary Care, Outpatient & Inpatient

# VHA/DoD Key Points Cards
# Primary Care, Specialty & Inpatient



**VA/DoD Clinical Practice Guideline for Management of Major Depressive Disorder in Adults: Inpatient Care**

1. Evaluate and
   - ➢ Suicidal r
   - ➢ Violent be
2. Conduct comp
   - ➢ History, M
   - ➢ Meets crit
   - ➢ DSM-IV
3. Initiate treatm
   - ➢ Antidepre (SSRI is c
   - ➢ ECT if pr (psychotic

**VA/DoD Clinical Practice Guideline Management of Major Depressive Disorder (MDD) in Adults: Outpatient Mental Health Specialty Setting**

**1. Evaluate for serio**
Dangerousness, uns
condition - handle

**2. Assess for MDD**
• Use DSM-IV crite
(e.g. Beck Depress

Assess for depres
(1 or 2 of the 5 sy
Sleep (__or __), I
Psychomotor char

Assess current M
response, and side

**VA/DoD Clinical Practice Guideline for Major Depressive Disorder in Adults: Primary Care**

1. Screening – Routine in primary care. ('yes' to either Q below = positive screen)
   - ➢ YES/NO: During the past month, have you often been bothered by feeling down, depressed, or hopeless?
   - ➢ YES/NO: During the past month, have you often been bothered by little interest or pleasure in doing things?
2. Consider for emergent triage: Delirium, acute or marked psychosis, severe depression (e.g. catatonia, malnourishment), acute danger to self or others, or unstable acute medical conditions.
3. Assess for "red flags". High index of suspicion for depression if…
   unexplained symptoms, chronic illness, decreased function, hx of abuse/neglect, family hx, significant losses, other psychiatric problems
4. Assess for depressive episode. 5 or more of "sig-e-caps" for at least two weeks
   (1 or 2 of the 5 symptoms must be ▼ interest and/or depressed mood)
   Sleep (▲ or ▼), Interests (▼), Guilt, Energy (▼), Concentration (▼), Appetite (▲ or ▼), Psychomotor changes (▲ or ▼), Suicidal ideas.

# Pilot Sites
## *Depression Guideline*

- Ireland Army Community Hospital
  Fort Knox
- Walter Reed Army Medical Center
- DeWitt Army Community Hospital
  Fort Belvoir
- Tripler Army Medical Center
- Madigan Army Medical Center (informal)

# Piloting Process

- Local administrative and clinical "champions"
- Local implementation plan
- Coordination calls
- Site assessments at approximately 3 and 6 months
- Tools are improved based on experience
- Lessons learned are collated for general dissemination

# Lessons Learned
## *Depression*
## *Piloting*

- Champion ‘transitions’ and institutional knowledge
- Assessment form only necessary if patients screen positive
- Forms under-utilized – automation will help
- Referral form viewed as unnecessary
- Need to bundle ‘like’ guidelines for implementation planning
- Behavioral health satellite broadcast in Sep 02

# Concluding Review

- Why a guideline for depression?
- Main guideline elements
- Guideline tools
- Guideline piloting

# Performance Measures

- **Detection**
  Percent of patients seen in a general medicine, or primary care clinic who were screened for depression during the previous twelve (12) months.
- **Assessment**
  Percent of patients diagnosed with a depressive disorder during the previous 12 months.

# Performance Measures

- **Treatment**
  **Percent of patients newly diagnosed with and treated for major depressive disorder past twelve (12) months who continue on prescribed medication for at least 90 days in the next 120 days or at had least eight (8) psychotherapy sessions in the next 180 days.**

# Performance Measures

- **Effectiveness**
  **Percent of patients who were seen during the past 12 months with a diagnosis of major depression who have a systematic symptom assessment at 12 weeks following diagnosis or if in remission by week 12, a systematic symptom assessment at the time of the documented remission.**

# For More Information:

## VHA and MEDCOM Website URL

- MEDCOM Depression Guidelines Main Page:
  www.cs.amedd.army.mil/qmo/depress/depress.htm
- Toolkit and Supply Ordering Information:
  www.cs.amedd.army.mil/Qmo
- VHA Guidelines Home Page:
  www.oqp.med.va.gov/cpg/cpg.htm